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Original Article

Protective Factors of Demoralization among Cancer Patients in Taiwan: An Age-matched and Gender-matched Study

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SUMMARY

Purpose: This study aimed to explore the protective factors of demoralization in cancer patients via investigation of cancer patients' demographic and disease characteristics.

Methods: This was a cross-sectional descriptive study. We used a structured questionnaire, which contained items on demographic and disease characteristics, as well as the Demoralization Scale Mandarin Version (DS-MV), with a cutoff of 30 or more indicating high demoralization. Data were analyzed with age-matched and gender-matched conditional logistic regression analysis. For the study, 428 questionnaires were delivered and 411 were recovered. After being age-matched and gender-matched, 182 participants of high demoralization (DS-MV > 30) and low demoralization (DS-MV ≤ 30) were obtained respectively, for a total of 364 participants.

Results: Cancer patients' demoralization was significantly related to family support ($p = .019$), education ($p = .049$), and monthly income ($p = .001$). Family support [odds ratio = 0.38; $p = .028$; 95% confidence interval (0.16, 0.91)] and monthly income [odds ratio = 0.49; $p = .009$; 95% confidence interval (0.29, 0.84)] were protective factors of demoralization in cancer patients.

Conclusion: Early and appropriate demoralization assessment of cancer patients' demographic and disease characteristics is very important in clinical settings. Healthcare providers might regularly monitor demoralization in cancer patients, and develop related nursing care guidelines or treatment for demoralization in cancer patients. The study results can be a reference for healthcare providers who work with cancer patients.

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Introduction

Demoralization has arisen in the last decade as a new diagnosis of concern [1]. It refers to a sense of dysphoria involving feelings of disempowerment and futility [2,3]. Consequently, individuals with severe cases of demoralization could lead to suicidal ideation [4,5]. It has most often been reported among seriously ill patients, cancer patients, and hospice patients [1,3].

Demoralization has been an issue of concern among scholars since around 1967, when it was first defined. Since then, the phenomenon has had numerous epithets, including “social breakdown

syndrome” [6], “giving-up–given-up complex” [7], impotence, isolation, and despair [8]. In 1981, demoralization was first used in a clinical setting by the American psychiatrists Roberts and Vernon [9]. They found that many patients with affective disorders or schizophrenia in the community suffered from feelings of demoralization. However, it was not until 2001 when an Australian scholar proposed the concept of “demoralization syndrome” [10] that it became diagnosable according to formalized criteria [2]. Until 2011, demoralization had widely been used to describe a nonspecific state of suffering related to feelings of impotence in facing certain pressures, or a subjective feeling of incompetence [11]. In 2004, Kissane et al developed the Demoralization Scale (DS) in order to quantify feelings of demoralization [12]. The DS has since been used in research on what factors are related to demoralization [13,14]. Although most research on demoralization has examined patients with serious illness [15], demoralization has

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been examined in other fields as well. For instance, some previous studies examined demoralization among refugee and migrant populations [16,17]. In recent years, the focus has shifted to cancer patients [18,19]. Based on the above literature, we would like to know how demoralization influences cancer patients in Taiwan and then make the study results available to other countries with similar situations. Even though there was a study on demoralization of cancer outpatients in Taiwan in 2012 [20], the factors which influence the demoralization of cancer inpatients are still vague. There is a need to conduct more studies to validate the theory and evidence of the related study.

Accordingly, we proposed the conceptual framework for the study (Figure 1). We assumed that the demographic and disease characteristics served as protective factors of cancer patients to reduce the level of demoralization. Regarding the demographic characteristics, cancer patients who had higher levels of family support, education, monthly income, and lived with family members had lower levels of demoralization. Regarding the disease characteristics, cancer patients who had earlier stages of tumor, initial diagnosis, and had undergone surgery had lower levels of demoralization.

Method

Study design and participants

This study was a cross-sectional descriptive study using data from adult cancer patients who were hospitalized at a medical center in Southern Taiwan. Inclusion criteria were being (a) above 20 years of age, (b) able to speak Chinese or Taiwanese, and (c) able to express their own opinions or fill in the questionnaire. Exclusion criteria were (a) being unconscious, and (b) being diagnosed with an organic brain disorder by a physician. Data were collected from July to December 2014.

The results of a power analysis based on logistic regression found that 356 participants were needed to meet the statistical

criteria to achieve power of 80% using a two-sided test, and a significance level of 5% for a medium effect size [21]. To account for a 20.0% maximum dropout rate, we needed to enrol 428 participants. In the study, 428 questionnaires were delivered and 411 were recovered, with a response rate of 96.0%. After being age-matched and gender-matched, 182 participants of high demoralization and low demoralization respectively were included for statistical analysis, for a total of 364 participants.

Measurements

A letter of permission to use the Demoralization Scale Mandarin Version (DS-MV) was obtained from the original author. The study used a structured questionnaire for data collection. One research assistant, a registered nurse with 3 years of experience as head nurse of a psychiatric unit, was recruited. The research assistant checked for newly hospitalized cancer patients in the hospital information system daily, screened patients for inclusion criteria and exclusion criteria, and then matched and contacted them to confirm that they were aware of their diagnosis. Then, the research assistant explained the research purpose and procedure to all recruited participants. The questionnaire was only administered after the participants had given their written informed consent, while participant autonomy was respected during questionnaire completion. Furthermore, participants were informed that they could stop filling in the questionnaire at any point. The research assistant accompanied participants and answered their questions during the whole procedure. If participants were found to have an affective disorder, appropriate support was given and their primary physician was notified for assistance. For participants who were unable to complete the questionnaire by themselves, the research assistant read the items and answer options to help them select answers. It took about 15 minutes to complete each questionnaire.

The questionnaire of demographic and disease characteristics included items on demographic (gender, age, marital status, children, education, monthly income, and living status) and disease

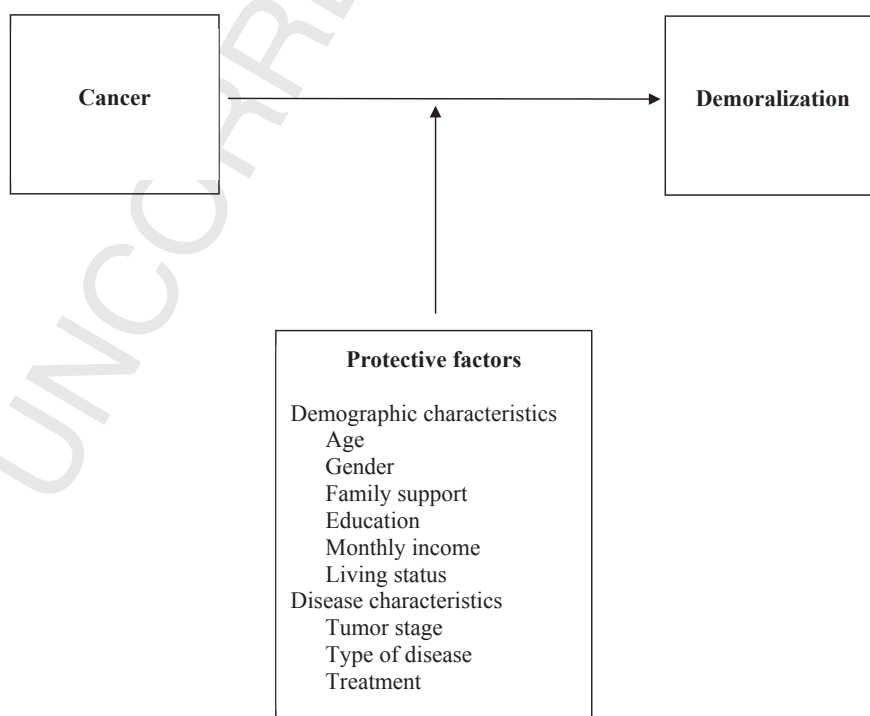


Figure 1. Conceptual framework of this study.

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